Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA RD
PASADENA TX 77504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-06-1371-01

MFDR Date Received

October 21, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The 'Ingenix Range' was 213.3% to 290% of the Medicare rate in effect at the time for the procedure. Simple procedures would be reimbursed at the lower end of the Ingenix Range while more complex procedures would be reimbursed at the higher end of the scale. Therefore, reimbursement should be in an amount which is applicable Medicare reimbursement rate at the time of the date of service multiplied by 213.3% to 290% depending on the complexity of the procedure performed. In the case of outliers, greater reimburse should be allowed… Further, or in the alternative, because the DWC considers the applicable requirements in Labor Code section 413.011 (d) for determining a fair and reasonable reimbursement when it issues its fee guidelines, the amount I the 2008 Outpatient Hospital Facility Fee Guidelines, with some adjustment, is fair and reasonable in this case.."

Amount in Dispute: $24,810.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on the Table of Disputed Services: "Payment has been issued in accordance with the Texas WC Fee Schedule."

Response Submitted by: Ace American Insurance Co., PO Box 759, Houston, TX 77001

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2005	Outpatient Hospital Services	$24,810.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that

"Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made on insurance carrier fair and reasonable reimbu
   - 42- Charges exceed our fee schedule or maximum allowable amount.
   - 50 – These are non-covered services because this is not deemed a ¢medical necessity' by the payer.
   - 97 – Payment is included in the allowance for another service/procedure.
   - 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The carrier denied services using the denial code 50 - "These are non-covered services because this is not deemed a 'medical necessity' by the payer" and 151 - "Payment adjusted because the payer deems the information submitted does not support this many services." The respondent did not submit documentation to support the position that the disputed service was not medically necessary or that the documentation submitted by the requestor did not support this many services. The Division therefore concludes that these denial reasons are not supported. The services will be reviewed per applicable statutes and Division rules.
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Further, or in the alternative, because the DWC considers the applicable requirements in Labor Code section 413.011(d) for determining a fair and reasonable reimbursement when it issues its fee guidelines, the amount I the 2008 Outpatient Hospital Faciltiy Fee Guidelines, with some adjustment, is fair and reasonable in this case..."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the comparison of charges to other carriers was not presented for review.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "…reimbursement should be an amount which is the applicable Medicare reimbursement rate at the time of the date of service multiplied by 213.3% to 290% depending on the complexity of the procedure preformed...."
   - In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 4, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.